Letter No.: 01-02

DEPARTMENT OF HEALTH SERVICES

714/744 P Street P.O. Box 942732 Sacramento, CA 94234-7320 (916) 657-0258



January 02, 2001

To: All County Welfare Directors

All County Administrative Officers

All County Medi-Cal Program Specialists/Liaisons

All County Mental Health Directors All County Public Health Directors

SECOND YEAR OF TRANSITIONAL MEDI-CAL (TMC) STATUS REPORTING CHANGES

Ref.: All County Welfare Directors (ACWDL) Nos. 98-56 and 99-55

The purpose of this letter is to inform counties that as of January 2001, status reporting for the second year of TMC is no longer required. Senate Bill (SB) 87 Chapter 1088, September 30, 2000, amended Section 14005.81 which deletes those requirements. These changes affect Aid Codes 5X and 5Y. Beneficiaries are still required to report significant changes such as income and family composition within ten days.

SB 87 also requires the Department to seek a federal waiver to delete status reporting for the first year of federally funded TMC. Unless the waiver is approved, reporting is still required for those persons. Families who do not return the status report in the fourth month (without good cause) are not eligible for the second six months of TMC. Families who do not return the status report in the second six-month period (without good cause) or who do not meet the other requirements such as earned income at or below 185 percent of the federal poverty level, are also ineligible.

ACWDL No. 98-56 discussed the possibility of reporting second year TMC pregnant women who are eligible for the Income Disregard Program to the Medi-Cal Eligibility Data System (MEDS) to secure federal financial participation. We have been informed that MEDS will now allow counties to report the secondary pregnancy aid codes (44 and 48) to MEDS if the primary aid code is non-federal, Medically Indigent, or a limited scope zero share of cost. Therefore, we are requesting that you report both state only TMC and pregnancy only aid codes to MEDS if the TMC woman is pregnant and eligible for the Income Disregard Program.

All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Mental Health Directors
All County Public Health Directors
Page 2

We are in the process of modifying the MC 239 TMC second year TMC Notice of Action to delete the references to status reporting. A draft is enclosed for your information. A camera-ready copy in English and Spanish will be sent when they are available.

The MC 176 TMC and the MC 176 TMC A (pin feed form) have been revised so that counties will have more information to determine whether the family is eligible for Section 1931(b) or another program if the family's earned income decreases during the first year of TMC or they are no longer eligible for TMC. Camera-ready copies are enclosed. The Spanish versions will be sent when they are available.

If you have any further questions, please contact Ms. Margie Buzdas of my staff at (916) 657-0726.

Sincerely,

ORIGINAL SIGNED BY

Glenda Arellano Action Chief Medi-Cal Eligibility Branch

Enclosure

MEDI-CAL NOTICE OF ACTION SECOND YEAR OF TRANSITIONAL MEDI-CAL (TMC) APPROVAL FOR BENEFITS

	(COUNTY	STAMP)	
Notice date:			
Case number:			
Worker name/	number:		
Worker teleph	one number:		
This affects:			

A SECOND YEAR OF TMC IS AVAILABLE TO WORKING PERSONS AGE 19 AND OVER WHO RECEIVED ONE YEAR OF TMC BECAUSE THEY WERE NO LONGER ELIGIBLE FOR THEIR CURRENT MEDI-CAL PROGRAM DUE TO EMPLOYMENT.

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You are	eligible	tor up	to 12	additional	months	of HMC	at no	cost for	tne per	ioa		trirougn
You are	entitled	to full	benefi	ts.								

- Your benefits only cover emergency and pregnancy-related services

You must:

- Continue to be employed.
- Have an eligible child in the home.
- Have average earnings minus child care costs at or below 185 percent of the Federal Poverty Level.
- Report any changes in your income or household composition with ten days.

Always present your Benefits Identification Card (BIC) to your medical provider whenever you need care. This card is good as long as you are eligible for Medi-Cal. DO NOT THROW AWAY YOUR BIC.

The regulation which requires this action is California Code of Regulations, Title 22, Section 50244.



TRANSITIONAL MEDI-CAL (TMC) QUARTERLY STATUS REPORT

This status repor	t is for the month	Return this form no later than	
Month 1	Month 2	Month 3	the 21st day Of

IMPORTANT: COMPLETE, SIGN, AND RETURN THIS REPORT TO THE WELFARE DEPARTMENT IN THE ENCLOSED ENVELOPE. Attach proof of your income, actual child care expenses paid, and total hours of employment for the three months noted above. If you have any questions regarding this form or the items to be reported, contact your eligibility worker. r 1 . For Transitional Medi-Cal (TMC)-You will receive status reports during this period. If you do not complete and return these reports, your eligibility for TMC will be discontinued. PART A. DISCONTINUANCE REQUEST I request that my Transitional Medi-Cal be stopped on the last day of Month/Year I know that I can reapply for Medi-Cal at any time. Applicant signature Date IF YOU WANT YOUR TMC ELIGIBILITY TO CONTINUE, PLEASE COMPLETE AND SIGN PART B OF THIS REPORT. PART B. ELIGIBILITY STATUS INFORMATION Did anyone receive any income, money, or benefits during the report period such as salary, wages, tips, commissions, vacation pay? If yes, attach proof (all pay stubs) for each report month. 🗖 Yes Name Month 1 Month 2 Month Yes Income received? Yes Yes Employer/source O No □ No ΠNo Total hours worked: Name Month 1 Month 2 Month 3 Yes Yes Yes Employer/source □ No □ No ☐ No Total hours worked Name Month 1 Month 2 $Month \ 3$ Yes Yes ☐ Yes Income received? Employer/source □ No O No O No. Total hours worked Name Month 2 Month Month Yes Yes Income received? Yes ☐ No Employer/source □ No □ No Total hours worked: Did you or any family member receive money or benefits from other sources such as disability, unemployment, child support, or social security? If yes, attach proof (all pay stubs) for each report month. 🗍 Yes □ No Name Month 1 Month 2 Month ☐ Yes Yes Income received? ☐ Yes Employer/source □ No □ No □ No Name Month 1 Month 2 Month 3 Yes Yes 🛮 Yes income received? Employer/source ΠNo o No □ No Name Month 1 Month 2 Month 3 Ye5 Yes Yes Income received? Employer/source □ No Ū No □ No

MC 176 TMC (11/00)

4. Did you or anyone pay for child care expenses which have not or will not be reimbursed? Yes	3.	 a. Did you or any family member receive for b. Did you or any family member work for If yes to 4a and 4b, you must answer the the 	Yes Yes	□ No □ No					
Summer of Child(pen) Age						(3) V	Vho provided it?		
So Did you have changes in your family or household during the time specified? (Include change of address, change of child care provider, change of employment, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) Name	4.		which h	ave not or wil	I not be reim	bursed?		☐ Yes	□No
5. Did you have changes in your family or household during the time specified? (Include change of address, change of child care provider, change of employment, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) Name		Name of Child/ren)	Ago		T	- ·	Name of Ci	nild Care Prov	ider
change of child care provider, change of employment, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) Yes		Name of Clinic(ten)	Aye	month 1	MOIITH Z	month 3	Humo or or		
change of child care provider, change of employment, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) Yes									
change of child care provider, change of employment, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) Yes		-	1						
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change of child care provider, change of employment, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) Yes									
6. a. Do you or anyone have or expect to receive private health, vision, or dental insurance? (This includes insurance paid by an absent parent.) b. Do you have or expect to receive health insurance through your employer? CERTIFICATION I understand that reported facts may result in benefits being changed or stopped. I understand that the statements I have made on this form are subject to investigation and verification. I understand that I must notify my worker within ten days of any change. I understand that failing to report facts or giving wrong or incomplete facts can result in legal prosecution with penalties of a fine, imprisonment, or both. I DECLARE UNDERPENALTYOF PERJURYUNDERTHE LAWS OF THE UNITED STATES AND THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUE AND CORRECT AND IS COMPLETE FOR THE ENTIRE REPORT PERIOD. Signature or mark of applicant Date Phone number ()	5.	change of child care provider, change of employ of your home, is pregnant, or anyone who was	ment, ch a	ange in prope		•		☐ Yes	□No
insurance paid by an absent parent.) b. Do you have or expect to receive health insurance through your employer? c. Does your employer offer health insurance for a monthly premium? If yes, complete the following: Name of Insurance		N a m e	Rela	ationship		What Happe	ned	1	Date
insurance paid by an absent parent.) b. Do you have or expect to receive health insurance through your employer? c. Does your employer offer health insurance for a monthly premium? If yes, complete the following: Name of Insurance								1	
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Signature of witness lo mark, interpreter, or other person Date Phone number	Signa	ature or mark of applicant			Dale		Phone nu	mber	
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TRANSITIONAL MEDI-CAL (TMC) QUARTERLY STATUS REPORT

This status report	is for the months	of	Return this form no later than
Month 1	Month 2	Month 3	the 21st day of

IMPORTANT: COMPLETE, SIGN, AND RETURN THIS REPORT TO THE WELFARE DEPARTMENT IN THE ENCLOSED ENVELOPE. Attach proof of your income, actual child care expenses paid, and total hours of employment for the three months noted above. If you have any questions regarding this form or the items to be reported, contact your eligibility worker.

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For Transitional Medi-Cal (TMC)-You will receive status reports during to your eligibility for TMC will be discontinued.	this period. If you d	lo not comple	te and return the	ese reports,
ART A. DISCONTINUANCE REQUEST				
request that my Transitional Medi-Cal be stopped on the last day of				
know that I can reapply for <i>Medi-Cal</i> at any time.	Month/Year pplicant signature		Date	<u> </u>
IF YOU WANT YOUR TMC ELIGIBILITY TO CONTINUE, PLEASE	COMPLETE AND	SIGN PART B	OF THIS REPO	RT.
ART B. ELIGIBILITY STATUS INFORMATION				
Did anyone receive any income, money, or benefits during the report per commissions, bonuses, vacation pay? If yes, attach proof (all pay students)	-		☐Yes	□No
Name	ibs) for each report	Month 1	Month 2	Month 3
Employer/source	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours	worked:	Terror or or William .	
Name Employer/source	Income received?	Month 1 ☐ Yes	Month 2 ☐ Yes ☐ No	Month 3
Employer/source	Total hours worked:	□ No 		□ No
N a m e		Month 1	Month 2	Month 3
Employer/source	Income received? Total hours worked:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name		Month 1	Month 2	Month 3
Employer/source	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hou	rs work	e d :	
Did you or any family member receive money or benefits from other sour child support, or social security? If yes, attach proof (all pay stubs) for		y, unemploym	ent,	□No
Name	Income received?	Month 1 ☐ Yes	Month 2 ☐ Yes	Month 3
Employer/source		□No	☐ No	☐ No
N a m e		Month 1	Month 2	Month 3
Employer/source	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
N a m e	Income received?	Month 1	Month 2	Month 3
Employer/source	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3.	 a. Did you or any family member receive free housing, utilities, food, or clothing in the report month? b. Did you or any family member work for housing, utilities, food, or clothing in the report month? If yes to 4a and 4b, you must answer the three questions on the next line. 							□ No □ No
	(1) What was received?	(2) Who re	eceived it?		(3)	Who provided it?	,	
4.	Did you or anyone pay for child care expenses If yes, complete the following:	which ha					☐ Yes	□No
	Name of Child(ren)	A	Amount Pa	id for Child Ca Month	re Expenses	Nama	of Child Care Provi	dor
	Name of Cimulten)	Age	MOIIII	WOIITI	Z Month	Name	or Cilità Care Frovi	uei
			ļ					
	-	1		1				
5.	Did you have changes in your family or house change of child care provider, change of emploof your home, is pregnant, or anyone who was If yes, complete the following:	yment, ch	ange in prope		•		☐ Yes	□No
	N a m e	Rel	ationship		What Hap	pened	D	ate
							-	
6.	 a. Do you or anyone have or expect to recinsurance paid by an absent parent.) b. Do you have or expect to receive health c. Does your employer offer health insurance If yes, complete the following: 	insurance	through your	employer?	insurance? (T	his includes	☐ Yes ☐ Yes ☐ Yes	□ No □ No □ No
	Name of Insurance					Person(s) insure	ed	
			-					
CE	RTIFICATION							
Ιu	nderstand that reported facts may result in benef	its being	changed or s	stopped.				
ur	nderstand that the statements I have made on thi	s form a	re subject to	investigation a	nd verification.			
l ur	nderstand that I must notify my worker within ten	days of a	ny change.					
l ur	nderstand that failing to report facts or giving	wrong (or incomplete	e facts can r	esult in lega	al prosecution	n with penalties	of a fine,
•	isonment, or both.	IDED TI			074750 44	.D. T. IE OT A T		
	ECLARE UNDER PENALTY OF PERJURY UN INFORMATION CONTAINED IN THIS REPORT		_	_	_	_		
Signat	ure or mark of applicant				Dale	Pho	ne number	
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Signat	ure of witness to mark, interpreter, or other person				Date	Pho	ne number	
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